Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: WALLS REGIONAL HOSPITAL 3255 W PIONEER PKWY ARLINGTON TX 76013-4620	MFDR Tracking #:	M4-08-1508-01
Respondent Name and Box #: Texas Mutual Insurance Co. Box #: 54		

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "We have found in this audit that the carrier, Texas Mutual did not pay what we determined to be a fair and reasonable amount. **The average payment for HCPCS 62284 is $587.49**, and the carrier only paid $242.94."… "Though there is no specific guideline to follow for outpatient surgery we believe paying the average rate would be fair."

Principle Documentation:

1. DWC 60 Package
2. Total Amount Sought - $344.55
3. Hospital Bill
4. EOBs
5. Medical Records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "The requestor is a voluntary participant in Medicare. The APC reimbursement form Medicare is $157.01 for code 72265, APC 274. The total APC amount payable under Medicare is $157.01. The code frequently used by facilities for reimbursement purposes, 62284, is for physician use only, therefore, payment is based on code 72265."… "Texas Mutual paid $242.94, which it believes is more than fair and reasonable for the lumbar myelogram."… "Texas Mutual believes the requestor has failed to show Texas Mutual's payment amount is not fair and reasonable nor has the requestor demonstrate its proposed payment of $587.49 is. In the absence of such demonstration Texas Mutual asserts no additional payment is due."… "Texas Mutual believes the amount paid to be fair and reasonable payment consistent with the Labor Code, in the absence of a hospital outpatient fee guideline."

Principle Documentation:

1. Response Package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
4/11/2007	CAC-W10, CAC-97, CAC-W4, 217, 426, 891	Outpatient Surgery	$344.55	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code § 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule at 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective May 2, 2006 set out the reimbursement guidelines.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
   - CAC-W10 – "No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology."
   - CAC-97 – "Payment is included in the allowance for another service/procedure."
   - CAC-W4 – "No additional reimbursement allowed after review of appeal/reconsideration."
   - 217 – "The value of this procedure is included in the value of another procedure performed on this date."
   - 426 – "Reimbursed to fair and reasonable."
   - 891 – "The insurance company is reducing or denying payment after reconsideration."
2. This dispute relates to outpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 2, 2006, 31 TexReg 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. Division rule at 28 TAC §133.307(c)(2)(A), effective December 31, 2006, and applicable to disputes filed on or after January 15, 2007, 31 TexReg 10314, requires that the request shall include "a copy of all medical bill(s)"… "as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration in accordance with §133.250 of this chapter"… This request for medical fee dispute resolution was received by the Division on October 31, 2007. Review of the documentation submitted by the requestor finds that the requestor has not provided a copy of all medical bill(s) as originally submitted to the carrier and as submitted for reconsideration. The requestor has therefore failed to complete the required sections of the request in the form and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(c)(2)(A).
5. Division rule at 28 TAC §133.307(c)(2)(F)(iii), effective December 31, 2006, 31 TexReg 10314, and applicable to disputes filed on or after January 15, 2007 requires that the request shall include "a position statement of the disputed issue(s) that shall include"… "how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues"… Review of the requestor's position statement finds that the requestor has not discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The Division concludes that the requestor has not completed the required sections of the request in the form and manner prescribed by the Division as required by Division rule at 28 TAC §133.307(c)(2)(F)(iii).
6. Division rule at 28 TAC §133.307(c)(2)(F)(iv), effective December 31, 2006, 31 TexReg 10314, and applicable to disputes filed on or after January 15, 2007 requires that the request shall include "a position statement of the disputed issue(s) that shall include"… "how the submitted documentation supports the requestor position for each disputed fee issue"… Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not completed the required sections of the request in the form and manner prescribed by the Division as required by Division rule at 28 TAC §133.307(c)(2)(F)(iv).
7. Division Rule at 28 TAC §133.307(c)(2)(G) , effective December 31, 2006, and applicable to disputes filed on or after January 15, 2007, 31 TexReg 10314, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable"... The requestor's position statement asserts that "**The average payment for HCPCS 62284 is $587.49**, and the carrier only paid $242.94."… "Though there is no specific guideline to follow for outpatient surgery we believe paying the average rate would be fair." Review of the submitted documentation finds that the requestor did not provide evidence to support that a methodology based on payment of the average payment rate would yield a fair and reasonable reimbursement. The requestor does not explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, ensure that similar procedures provided in similar circumstances receive similar reimbursement, or otherwise satisfy the statutory requirements and Division rules. Nor did the requestor submit convincing evidence, such as redacted EOBs showing typical carrier payments, nationally recognized published studies, or Division medical dispute decisions to support that payment of the amount sought would be a fair and reasonable reimbursement. The requestor did submit a statement of previous payments for HCPCS code 62284 for nine other patients from the requestor's "UCR database"; however, the requestor did not provide EOBs, reports from the data base, screen prints, service dates, selection criteria

or other data to support the "average payment" calculation or demonstrate how the summary was compiled. Additionally, the requestor listed HCPCS code 72265 as a disputed service on the *Table of Disputed Services*; however, the requestor did not submit any evidence to support a reimbursement amount for HCPCS code 72265. The submitted documentation is not sufficient to meet the requirements of Division rule at 28 TAC §133.307(c)(2)(G). Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment in the amount sought by the requestor would be a fair and reasonable rate of reimbursement for the services in dispute. Additional reimbursement cannot be recommended.

8. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(c)(2)(A), §133.307(c)(2)(F)(iii), §133.307(c)(2)(F)(iv) and §133.307(c)(2)(G). The Division further concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.250, §133.307, §134.1
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the Requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.